STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
http://welfare.state.nv.us

CHANGE REPORT FORM

THE LAW SAYS YOU MUST REPORT CHANGES TO US WITHIN 10 DAYS AFTER THE CHANGE HAPPENS IF YOU ARE RECEIVING FOOD STAMP BENEFITS AND BY THE 5TH OF THE FOLLOWING MONTH FOR TANF AND/OR MEDICAID.
Fill in the spaces below. (You can write an explanation on a separate sheet of paper.) You can mail or bring this report into the office.
PLEASE PROVIDE PROOF OF THE CHANGES.

NAME	SOCIAL SECURITY NO. / /
ADDRESS APT #	TELEPHONE _ _
CITY/ZIP CODE	E-MAIL

Is this a new address? ☐ YES ☐ NO

MAILING ADDRESS (If different) _____

If you moved, please list the names of **everyone** living at your new address below.

PEOPLE CHANGES: Did someone ☐ move in ☐ or out ☐ or have a baby?

NAME	DATE MOVED IN OR OUT	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP
	_ _	_ _	/ /	
	_ _	_ _	/ /	

INCOME AND JOB CHANGES

Did someone get a new job or end a job? ☐ YES ☐ NO Who? _____ When? _ _

Did someone change work hours or pay? ☐ YES ☐ NO

Place of employment _____ Hours worked per week _____ Hourly Rate $_____ Date of first paycheck _ _

Day of Week Paid _____ Pay is weekly, biweekly, semi monthly or monthly? _____

Are tips received? If so, how much per month? $ _____

Medical insurance available? ☐ YES ☐ NO Effective Date: _ _ _____

OTHER INCOME CHANGES (Unemployment benefits, Social Security benefits, SSI, disability, child support, etc.)
Explain type of income and change:

How much is received each month? $ _____ Who receives this income? _____

EXPENSE CHANGES

New rent/mortgage payment? $ _____ Do you pay utility bills? ☐ YES ☐ NO

Child Care Expenses? $ _____

Medical expenses for the elderly (60+) or disabled? _____

Does anyone pay part of these expenses? Explain:

New child support you are ordered to pay? $ _____

RESOURCE CHANGES

You must report any changes in resources (checking/savings accounts, bonds, home/land, boat, life insurance, vehicles, etc.).
Include specific information about the opening, closing, purchasing, selling of, or changes to resources. Explain:

Other changes not listed above, i.e., pregnancy:

PLEASE READ AND SIGN: "I understand the penalty for hiding information or giving false information. I understand that I must repay the value of any benefits I get because I did not report changes or failed to report changes timely. I understand I may be disqualified from getting benefits. I can be fined or prosecuted or both if I do not tell the truth. I agree to provide proof of any changes if asked to do so. My answers on this form are true, correct and complete to the best of my knowledge."

Your Signature Date

PROVIDE PROOF OF CHANGES

IF WE CHANGE YOUR BENEFITS WE WILL SEND YOU A NOTICE.